Department of HUMAN SERVICES

INFORMATIONAL LETTER NO.2057-MC-FFS

DATE: November 19, 2019

TO: Iowa Medicaid Ambulance Providers

APPLIES TO: Managed Care (MC), Fee-for-Service (FFS)

FROM: Iowa Department of Human Services (DHS), Iowa Medicaid Enterprise (IME)

RE: Ground Emergency Medical Transportation (GEMT) Prospective Payment Program

EFFECTIVE: July 1, 2019

The Iowa Department of Human Services (DHS), Iowa Medicaid Enterprise (IME) has received approval from the Centers for Medicare and Medicaid Services (CMS) to provide prospective payments for Ground Emergency Medical Transportation (GEMT) claims submitted to the IME and Managed Care Organizations (MCOs). The prospective GEMT supplemental payments are to reimburse eligible providers their average uncompensated care cost (UCC) per transport.

What is the GEMT Prospective Payment Program?

The Iowa State Legislature created the GEMT Prospective Payment Program through House File 2285 during the 2018 session. The program makes provider-specific prospective payments to qualified publicly owned or operated GEMT providers.

The prospective payments cover the difference between a provider's actual and allowable costs per transport and the allowable amount received from Iowa Medicaid and any other sources of reimbursement for covered emergency ground transports.

Providers voluntarily participate in the GEMT Prospective Payment Program.

Who can participate?

Publicly owned or operated GEMT providers can participate in the GEMT Prospective Payment Program.

Eligibility Requirements

To be eligible for the GEMT Prospective Payment Program, providers must meet all of the following requirements continuously during the state fiscal year (SFY). The provider must

- provide GEMT services to Iowa Medicaid enrollees.
- be enrolled as an Iowa Medicaid provider.
- be owned or operated by an eligible governmental entity, to include the state, a city, county, fire protection district, health care district or other unit of government in the state that has taxing authority, has direct access to tax revenues, or is a federally recognized Indian tribe.

Can Private Providers Participate in the GEMT Prospective Payment Program?

In compliance with federal law and regulations, a GEMT "provider" means an entity, owned or operated by local government, a state agency, or federally recognized Indian tribe, that employs or contracts with individuals licensed by the State of Iowa to provide GEMT services. Therefore, public-private partnerships are allowable under the GEMT Prospective Payment Program with certain criteria and stipulations.

On May 14, 2014, CMS issued a State Medicaid Directors Letter (SMDL) 14-004[1], which offered guidance on how CMS interpreted and applied the statutory and regulatory restrictions on the use of provider donations to finance Medicaid payments. SMDL 14-004 indicates that public-private arrangements of various kinds can be mutually beneficial and promote shared public and organizational purposes. However, the SMDL explains, public-private partnerships in which "private entities provide a governmental entity with funds or other consideration and receive in return additional Medicaid payments typically in the form of a supplemental payment" would not be considered bona fide and therefore the resulting expenditures, such as supplemental payments, would not be allowed for Federal Financial Participation (FFP). This would preclude partnerships in which the funds for Intergovernmental Transfers (IGT) to fund such payments are derived from the private entity taking over the expenditures for a service previously paid for by the public entity.

Federal regulations at 42 C.F.R. § 433.52, which implement section 1903(w) of the Social Security Act define a provider related donation as "a donation or other voluntary payment (in cash or in kind) made directly or indirectly to a state or unit of local government by or on behalf of a health care provider, an entity related to such a health care provider, or an entity providing goods or services to the state for administration of the state's Medicaid plan."

As set forth in 42 C.F.R. § 433.54(a) define a bona fide donation as "a provider-related donation…that has no direct or indirect relationship…to Medicaid payments made to (1) the health care provider; (2) any related entity providing health care items and services;

[1] https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-14-004.pdf

or (3) other providers furnishing the same class of items or services as the provider or entity." Additionally, 42 C.F.R. § 433.54(b) and (c), this does not include donations that are part of a hold harmless arrangement that directly or indirectly returns some or all of the donation to the provider, the provider class, or any related entity.

Per the regulation, "Provider related donations will be determined to have no direct or indirect relationship to Medicaid payments if those donations are not returned to the individual provider, the provider class, or related entity under a hold harmless provision or practice." 42 C.F.R. § 433.54(b). In addition, a "hold harmless" relationship exists if any of the following are true:

1) The State (or other unit of government) provides for a direct or indirect non-Medicaid payment to those providers or others making, or responsible for, the donation, and the payment is positively correlated to the donation. A positive correlation includes any positive relationship between these variables, even if not consistent over time.
2) All or any portion of the Medicaid payment to the donor, provider class, or related entity, varies based only on the amount of the donation, including where Medicaid payment is conditional on receipt of the donation.
3) The State (or other unit of government) receiving the donation provides for any direct or indirect payment, offset, or waiver such that the provision of that payment, offset, or waiver directly or indirectly guarantees to return any portion of the donation to the provider (or other parties responsible for the donation)."

Therefore, in order to comply with federal regulations and SMDL 14-004, eligible contracting arrangements that satisfy the "owned or operated" eligibility requirement are as follows:

1. *Direct owner/operator:* If GEMT services are provided directly by a governmental entity, the entity's cost including its general and administrative overhead costs allocated to providing Medicaid GEMT services are eligible for the program and can be reported on the entity's GEMT cost report form. The governmental entity must bill for the services directly.
2. *Subcontracted GEMT services:* If GEMT services are provided by a governmental entity pursuant to a subcontract with a private entity, the governmental entity, to the extent it owns the private entity or is the "operator" of the private entity, may submit its commercially reasonable contract costs associated with the Medicaid GEMT services provided, as well as the governmental entity's billing costs and general and administrative overhead costs allocated to providing Medicaid GEMT services. Under no circumstances may the arrangement with the private entity permit the supplemental GEMT payments to be paid to the private entity or to, in any way, financially supplement that arrangement.

3. *Any other public/private arrangement.* In any other public/private arrangement to provide Medicaid GEMT services, the arrangement must provide that the governmental entity is the owner and/or operator of the GEMT service, and the cost to the governmental entity for Medicaid GEMT services must be established in the arrangement in advance and be commercially reasonable. The governmental entity may submit its contract costs as well as the governmental entity's billing costs and general and administrative overhead costs allocated to providing Medicaid GEMT services. Under no circumstances may the arrangement with the private entity permit the supplemental GEMT payments to be paid to the private entity or to, in any way, financially supplement that arrangement.

In all scenarios, the governmental entity must enter into an IGT Agreement between the eligible public provider and Iowa DHS and must comply with the requirements of 42 C.F.R. § 433.51.

How does a provider voluntarily participate in the GEMT Prospective Payment Program?

Eligible providers that voluntarily participate in the SFY 2020 and 2021 period must:

- Complete and submit the annual GEMT cost report for SFY 2018 and 2019 reporting periods.
- Complete and submit an IGT Agreement for funding of the non-federal share of payments.

A provider must complete, sign and print the cost reports and IGT Agreement in their entirety. Scan and email the signed PDF of the IGT Agreement and GEMT cost report certification pages and the Excel version of the GEMT cost report to costaudit@dhs.state.ia.us by December 31, 2019.

For eligible providers that continue participation or new eligible providers starting participation in the SFY 2022 period, such providers must complete and submit the GEMT cost report for the SFY 2020 reporting period and IGT Agreement by November 30, 2020.

Provider-specific GEMT Supplemental payment rate

The initial payment rate for all participating providers will be a statewide average rate of $1,183.97 per transport. Based on review of the submitted GEMT cost reports, the IME will establish and notify providers of their provider-specific average UCC per transport for July 1, 2019, and the July 1, 2020, rate.

Adjustment to the July 1, 2020, rate will occur for any overpayment or underpayment that resulted from the initial statewide rate of $1,183.97.

GEMT Claims Submission

Providers must submit all claims for eligible services to Iowa Medicaid or MCO in a timely manner.

Voluntarily participating providers must submit the claim as follows:

- Use one of the appropriate emergency transportation procedure codes: A0225, A0427, A0429 or A0433.
- Use mileage procedure code A0425.
- An additional line item entry using procedure code A0999 is required for providers to receive the prospective GEMT supplemental payment per transport rate. Procedure Code A0999 is set to pay the provider-specific GEMT supplemental per transport rate.
- Providers must bill their provider-specific GEMT supplemental payment per transport rate as the billed charge amount for procedure code A0999 to receive the full reimbursement. Medicaid reimbursement is the lower of the billed charge amount or the provider-specific GEMT supplemental payment per transport rate.
- There must be Iowa Medicaid payment for a covered GEMT transport (i.e., base rate and mileage) for the obligation to pay the GEMT supplemental payment per transport rate (procedure code A0999) can occur by Iowa Medicaid.

Providers that are participating in the program will be required to re-submit claims for services on and after July 1, 2019 to the IME and MCOs with the above requirements to receive the GEMT supplemental payment per transport rate.

The IME will notify providers through a separate Informational Letter when they can re-submit claims.

IGT Process

An IGT is a transfer of funds from one governmental entity (e.g. city, county, state, or federal) to the state Medicaid agency. The ability of states to use IGTs to fund their Medicaid program is recognized in Section 1903(w)(6) of the Social Security Act and 42 CFR 433.51.

IGTs cannot be derived from impermissible donations or taxes. Section 1903(w)(6) of the Social Security Act states:

(a) Public Funds may be considered as the State's share in claiming FFP if they meet the conditions specified in paragraphs (b) and (c) of this section.
(b) The public funds are appropriated directly to the State or local Medicaid agency, or are transferred from other public agencies (including Indian tribes) to the State or local agency and under its administrative control, or certified by the contributing public agency as representing expenditures eligible for FFP under this section.
(c) The public funds are not Federal funds, or are Federal funds authorized by

Federal law to be used to match other Federal funds.

Iowa Medicaid will invoice providers monthly for the non-federal share of the provider-specific GEMT supplemental payments, and participating providers will need to send the funds to the agency as an IGT. The monthly invoice amounts will be determined as follows:

Medicaid Managed Care	
Frequency	Monthly
Timing	IGT is due by the last day of the preceding month (i.e. the December 2019 IGT received by the Department no later than November 30, 2019).
Amount	Based on the provider-specific amount built into the capitation rates divided by 12 months. Updates to monthly IGT amounts could occur throughout the year due to federal match rate changes.

Medicaid Fee-for-Service (FFS)	
Frequency	Monthly
Timing	IGT is due by the last day of the preceding month (i.e. the December 2019 IGT received by the Department no later than November 30, 2019).
Amount	The IME is suspending claims received from the 16th of the month through the 15th of the next month until the Department receives the IGT amount. After receipt of the IGT amount, the State will release the Medicaid FFS claims for payment.

Iowa Medicaid will be in contact with participating qualifying providers to specify further detail regarding the payment process after receipt of the GEMT cost reports and IGT agreement.

Where can I get more information?

Electronic versions of the IGT Agreement, cost report, cost report instructions, and other program related documents and information is located at the GEMT[2] webpage.

If you have any questions regarding the GEMT Prospective Payment Program, please contact the IME PCA Unit at costaudit@dhs.state.ia.us or 1-866-863-8610.

[2] https://dhs.iowa.gov/ime/providers/tools-trainings-and-services/medicaid-initiatives/GEMT